FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038620

Facility Name: HERITAGE NURSING HOME, INC.

Address: 5888 N. RIDGE AVENUE (Number) CHICAGO (City) 60660 (Zip Code)

County: COOK

Telephone Number: 773-769-2626 **Fax #** 773-769-2650

IDPA ID Number: 36-3853045

Date of Initial License for Current Owners: 11/01/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) DANIEL SHABAT

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) DONALD MAGNUSON

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	44	Skilled (SNF)	44	16,104	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,744	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	128	TOTALS	128	46,848	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,913	206	725	10,844	8
9	SNF/PED					9
10	ICF	28,215	310		28,525	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,128	516	725	39,369	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.04%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/01/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/01/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 725

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	126,511	13,349	4,922	144,782		144,782		144,782			1
2	Food Purchase		179,710		179,710	(31,769)	147,941	(23)	147,918			2
3	Housekeeping	93,255	12,017		105,272		105,272		105,272			3
4	Laundry	38,977	15,927		54,904		54,904		54,904			4
5	Heat and Other Utilities			77,358	77,358		77,358		77,358			5
6	Maintenance	29,822	2,693	66,339	98,854		98,854	(31,650)	67,204			6
7	Other (specify):*											7
8	**TOTAL General Services**	288,565	223,696	148,619	660,880	(31,769)	629,111	(31,673)	597,438			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	988,245	47,992	10,564	1,046,801		1,046,801		1,046,801			10
10a	Therapy	56,450		4,515	60,965		60,965		60,965			10a
11	Activities	52,782	2,617	3,794	59,193		59,193		59,193			11
12	Social Services	28,702	272	4,908	33,882		33,882		33,882			12
13	Nurse Aide Training											13
14	Program Transportation			3,273	3,273		3,273		3,273			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,126,179	50,881	29,454	1,206,514		1,206,514		1,206,514			16
	C. General Administration											
17	Administrative	109,426		264,168	373,594		373,594	4,421	378,015			17
18	Directors Fees											18
19	Professional Services			113,819	113,819	(143)	113,676	(3,166)	110,510			19
20	Dues, Fees, Subscriptions & Promotions			17,583	17,583		17,583	(4,657)	12,926			20
21	Clerical & General Office Expenses	93,872	13,974	172,247	280,093		280,093	(159,902)	120,191			21
22	Employee Benefits & Payroll Taxes			287,395	287,395	31,769	319,164	(9,000)	310,164			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,204	4,204		4,204	(2,114)	2,090			24
25	Other Admin. Staff Transportation			965	965		965		965			25
26	Insurance-Prop.Liab.Malpractice			43,782	43,782		43,782		43,782			26
27	Other (specify):*							429	429			27
28	**TOTAL General Administration**	203,298	13,974	904,163	1,121,435	31,626	1,153,061	(173,989)	979,072			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,618,042	288,551	1,082,236	2,988,829	(143)	2,988,686	(205,662)	2,783,024			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

HERITAGE NURSING HOME, INC.
0038620
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	31,769	
2	FOOD		31,769

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	143	
19	PROFESSIONAL FEES		143

To reclass cost of appealing real estate taxes

Facility Name & ID Number HERITAGE NURSING HOME, INC. #0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			42,598	42,598		42,598	75,448	118,046			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,884	32,884		32,884	96,470	129,354			32
33	Real Estate Taxes			136,249	136,249	143	136,392		136,392			33
34	Rent-Facility & Grounds			339,648	339,648		339,648	(339,648)				34
35	Rent-Equipment & Vehicles			217	217		217		217			35
36	Other (specify):*											36
37	**TOTAL Ownership**			551,596	551,596	143	551,739	(167,730)	384,009			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,774	20,687	58,461		58,461		58,461			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,272	70,272		70,272		70,272			42
43	Other (specify):*	65,000		4,337	69,337		69,337	(69,337)				43
44	**TOTAL Special Cost Centers**	65,000	37,774	95,296	198,070		198,070	(69,337)	128,733			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,683,042	326,325	1,729,128	3,738,495		3,738,495	(442,729)	3,295,766			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	10,996	30		9
10	Interest and Other Investment Income	(19,645)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(23)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,850)	21		18
19	Entertainment	(2,114)	24		19
20	Contributions	(4,305)	20		20
21	Owner or Key-Man Insurance	(9,000)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(150,000)	21		24
25	Fund Raising, Advertising and Promotional	(131)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,052)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(105,574)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (289,698)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(153,031)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (153,031)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (442,729)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HERITAGE NURSING HOME, INC.

ID# 0038620

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	PROFESSIONAL FEES-BUILDING PARTNERSHIP	(1,200)	19	2
3	COPE (POLITICAL EDUCATION) CONTRIBUTION	(221)	20	3
4	PRIOR YEAR LEGAL	(3,166)	19	4
5	MARKETING SALARIES	(65,000)	43	5
6	MARKETING EXPENSE	(4,337)	43	6
7	ASSET ON CR, EXP ON FINANCL STATEMNT	(31,650)	6	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(105,574)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(23)											(23)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(31,650)											(31,650)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(31,673)											(31,673)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			4,421									4,421	17
18	Directors Fees													18
19	Professional Services	(4,366)	1,200										(3,166)	19
20	Fees, Subscriptions & Promotions	(4,657)											(4,657)	20
21	Clerical & General Office Expenses	(159,902)											(159,902)	21
22	Employee Benefits & Payroll Taxes	(9,000)											(9,000)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(2,114)											(2,114)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			429									429	27
28	**TOTAL General Administration**	(180,039)	1,200	4,850									(173,989)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(211,712)	1,200	4,850									(205,662)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	10,996	64,452										75,448	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(19,645)	116,115										96,470	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(339,648)										(339,648)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(8,649)	(159,081)										(167,730)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(69,337)											(69,337)	43
44	**TOTAL Special Cost Centers**	(69,337)											(69,337)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(289,698)	(157,881)	4,850									(442,729)	45

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED SCHEDULE		PRO HEALTH	BUFFALO GROVE	MANAGEMENT
				HERITAGE	CHICAGO	BUILDING CO
				HEALTHCARE		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 339,648	HERITAGE HEALTHCARE	100.00%	$	$ (339,648)	1
2	V	33	RENT-REAL ESTATE TAXES	136,249	HERITAGE HEALTHCARE	100.00%		(136,249)	2
3	V	19	ACCOUNTING FEES		HERITAGE HEALTHCARE	100.00%	1,200	1,200	3
4	V	33	REAL ESTATE TAXES		HERITAGE HEALTHCARE	100.00%	144,244	144,244	4
5	V	33	REAL ESTATE TAXES-PR YR		HERITAGE HEALTHCARE	100.00%	(7,995)	(7,995)	5
6	V	30	DEPRECIATION		HERITAGE HEALTHCARE	100.00%	64,452	64,452	6
7	V	32	INTEREST EXPENSE		HERITAGE HEALTHCARE	100.00%	116,332	116,332	7
8	V	32	INTEREST INCOME		HERITAGE HEALTHCARE	100.00%	(217)	(217)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 475,897			$ 318,016	$ * (157,881)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 9,941	$ 9,941	15
16	V	27	PAYROLL TAXES		PRO HEALTH CARE, INC.	100.00%	429	429	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MANAGEMENT FEES	5,520	PRO HEALTH CARE, INC.	100.00%		(5,520)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 5,520			$ 10,370	$ * 4,850	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

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1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STAN ARON	OWNER	ADMIN	7.22%	SEE ATTACHED	3	4.62%	ALLOC-PRO	$ 9,941	17-7	1
2	SYLVIA HERLIHY	ADMINISTRATOR	ADMIN	NONE	SEE ATTACHED	45	75.00%	SALARY	91,538	17-1	2
3								MGT FEE	1,290	17-3	3
4	DANIEL SHABAT	OWNER	ADMIN	18.05%	SEE ATTACHED	25	41.67%	MGT FEE	257,358	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 360,127		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60015
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED	51	4	$ 169,000	$ 169,000	3	$ 9,941	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	51	4	7,285		3	429	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 176,285	$ 169,000		$ 10,370	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Phone Number ( )
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SENN PARK MANAGEMENT		X	MORTGAGE	$20,958.31	12/01/92	$ 1,952,000	$ 1,141,996	12/01/06	9.66%	$ 116,332	1
2	LEXUS FINANCIAL SERVICE		X	AUTO LOAN	$677.23	4/02/98	27,245	10,083	4/02/02	8.17%	1,131	2
3												3
4												4
5												5
	Working Capital											
6	SHAREHOLDER LOAN	X		WORKING CAPITAL	NONE	11/02/92	500,000	500,000	12/31/00	IRS RATE	31,753	6
7												7
8												8
9	TOTAL Facility Related				$21,635.54		$ 2,479,245	$ 1,652,079			$ 149,216	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	INTEREST INCOME										(19,645)	11
12	INT INC-ALLOC HERITAGE HC										(217)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (19,862)	14
15	TOTALS (line 9+line14)						$ 2,479,245	$ 1,652,079			$ 129,354	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	148,039	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	140,043	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,996)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	144,244	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	143	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 430 For 19 93,94 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	136,391	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	125,525	8
	1996	128,614	9
	1997	138,530	10
	1998	140,989	11
	1999	140,043	12

1999 BILL INCREASED 3% FOR INFLATION : 140,043*1.03=144,244

THE TOTAL REFUND AMOUNT OF $430 CONSISTS OF A 1993 REFUND OF $185 AND 1994 REFUND OF $245.

THE REFUND WAS NOT OFFSET ON LINE 6 BECAUSE THE REFUND APPLIED TO A YEAR WHEN THE REAL ESTATE TAXES WERE NOT USED TO DETERMINE THE RATE.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,400 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NA

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1992	$ 105,600	1
2					2
3	TOTALS			$ 105,600	3

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	128		1991		$ 1,878,400	$ 59,632	35	$ 53,669	$ (5,963)	$ 536,690	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	22,988	653	20	1,150	497	8,898	9
10	Various			1994	38,610	771	20	1,682	911	10,744	10
11	Various			1995	68,517	1,843	20	3,427	1,584	18,533	11
12	ELECTRIC GENERATOR			1996	40,000	1,026	20	2,000	974	9,833	12
13	ELECTRIC CONVERSION			1996	28,148	722	20	1,407	685	6,449	13
14	GAS AIR CONDITIONER			1996	15,258	391	20	763	372	3,628	14
15	DRAPES			1996	18,329	667	20	916	249	4,351	15
16	DRAPES			1996	4,113	473	20	206	(267)	944	16
17	ELECTRICAL INSTALL			1996	825		20	41	41	198	17
18	SHOWER REPAIR			1996	980		20	49	49	245	18
19	BOILER ROOM BOOSTER			1997	675		20	34	34	113	19
20	GAS BOOSTER			1997	3,049		20	305	305	1,017	20
21	PIPING & PUMP			1997	742		20	37	37	120	21
22	FIRE PUMP ALARM			1997	3,425	88	20	171	83	556	22
23	WATER HEATER			1997	2,491	64	20	125	61	469	23
24											24
25	PAGE 12-1 REP TOTALS				252,187	4,820		7,919	3,099	169,818	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				25,366	29		620	591	620	34
35	PAGE 12A TOTALS				67,061	499		3,186	2,687	8,333	35
36	TOTAL (lines 4 thru 35)				$ 2,471,164	$ 71,678		$ 77,707	$ 6,029	$ 781,559	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PIPING & VALVES			1997	851		20	43	43	172	9
10	PAGE AMPLIFIER			1997	793		20	40	40	140	10
11	FIRE ALARM SYS			1997	600		20	30	30	105	11
12	ELECTRIC GENERATOR			1997	19,445	499	20	972	473	3,888	12
13	FIRE DOORS-6			1998	2,370		20	119	119	327	13
14	FIRE DAMPERS			1998	4,309		20	215	215	609	14
15	BATHROOM DOORS			1998	810		20	41	41	85	15
16	METAL GATES-STAIRWAY			1998	500		20	25	25	58	16
17	REPAIR 70 DOORS			1998	6,300		20	315	315	866	17
18	ELEV DOOR RESTRICTOR			1998	1,200		20	60	60	160	18
19	INSTALL FIRE DAMPERS			1998	3,782		20	189	189	441	19
20	FURNANCE			1999	1,495		20	75	75	150	20
21	PAINTING			1999	2,808		20	140	140	187	21
22	PLUMBING			1999	975		20	49	49	94	22
23	ELEVATOR REPAIR			1999	620		20	31	31	59	23
24	ALUMINUM DOORS			1999	2,280		20	114	114	190	24
25	AIR HANDLER			1999	675		20	34	34	45	25
26	ROOF EXHAUST FAN			1999	500		20	25	25	31	26
27	ELEVATOR IMPROVEMENT			1999	6,900		20	345	345	374	27
28	ELEVATOR PANELS			1999	610		20	31	31	59	28
29	WALL COVERING			2000	1,040		20	4	4	4	29
30	BOILER ROOM PUMP			2000	725		20	12	12	12	30
31	BURNER PILOT & CABLE			2000	843		20	42	42	42	31
32	FIRE PUMP			2000	1,050		20	53	53	53	32
33	JOCKEY PUMP			2000	1,885		20	94	94	94	33
34	FLOOR DRAIN			2000	2,500		20	83	83	83	34
35	TAPE PREP FOR PAINT			2000	1,195		20	5	5	5	35
36	TOTAL (lines 4 thru 35)				$ 67,061	$ 499		$ 3,186	$ 2,687	$ 8,333	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEV SWITCH&DR RESTR			2000	813		20	14	14	14	9
10	TILE & COVERING			2000	4,922		20	144	144	144	10
11	CORRIDOR HANDRAILS			2000	4,507	24	20	56	32	56	11
12	FIRE DOOR			2000	850	5	20	11	6	11	12
13	CARPETING			2000	942		20	4	4	4	13
14	COVE BASE			2000	152		20	3	3	3	14
15	BOILER			2000	1,500		20	75	75	75	15
16	PUMP BELT & HOSE			2000	728		20	21	21	21	16
17	WALLCOVERING			2000	1,414		20	24	24	24	17
18	PAINTING			2000	673		20	14	14	14	18
19	WALLPAPER			2000	580		20	15	15	15	19
20	WALLPAPER			2000	1,260		20	42	42	42	20
21	BEARING ASSEMBLY			2000	705		20	6	6	6	21
22	PUMP RUN RELAY			2000	1,884		20	39	39	39	22
23	WALLPAPER			2000	1,545		20	26	26	26	23
24	KEYPAD ALARM			2000	891		20	26	26	26	24
25	HOT WATER HEATER			2000	2,000		20	100	100	100	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 25,366	$ 29		$ 620	$ 591	$ 620	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS - HEALTHCARE			1992	23,467	407	20	1,174	767	9,864	9
10	VARIOUS - HEALTHCARE			1991	118,564	3,764	20	5,928	2,164	54,877	10
11	VARIOUS - HEALTHCARE			1990	4,919	156	20	246	90	2,519	11
12	VARIOUS - HEALTHCARE			1987	2,250		20	113	113	1,546	12
13	VARIOUS - HEALTHCARE			1986	5,000	300	20	263	(37)	3,781	13
14	VARIOUS - HEALTHCARE			1985	8,483	193	20	195	2	7,727	14
15	VARIOUS - HEALTHCARE			1983	6,069		20			6,069	15
16	VARIOUS - HEALTHCARE			1981	78,925		5			78,925	16
17	VARIOUS - HEALTHCARE			1978	4,510		5			4,510	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 252,187	$ 4,820		$ 7,919	$ 3,099	$ 169,818	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 343,872	$ 10,516	$ 32,835	$ 22,319		$ 254,384	37
38	Current Year Purchases	42,133	21,906	1,504	(20,402)		1,504	38
39	Fully Depreciated Assets	104,319					104,319	39
40								40
41	TOTALS	$ 490,324	$ 32,422	$ 34,339	$ 1,917		$ 360,207	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY USE	LEXUS-98-GS300	1998	$ 30,000	$ 2,950	$ 6,000	$ 3,050	5	$ 16,500	42
43										43
44										44
45										45
46	TOTALS			$ 30,000	$ 2,950	$ 6,000	$ 3,050		$ 16,500	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,097,088	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 107,050	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 118,046	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 10,996	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,158,266	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	EXCESS AUTO COST - 1998	$ 12,745	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 12,745	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

HERITAGE NURSING HOME, INC.
0038620
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
HERITAGE NURSING HOME INC	156,420	10,516	14,683	4,167	71,445
HERITAGE HEALTHCARE CENTER	187,452		18,152	18,152	182,939
TOTALS	343,872	10,516	32,835	22,319	254,384

LINE 29: CURRENT YEAR

HERITAGE NURSING HOME INC	42,133	21,906	1,504	(20,402)	1,504
HERITAGE HEALTHCARE CENTER					
TOTALS	42,133	21,906	1,504	(20,402)	1,504

LINE 30: FULLY DEPRECIATED

HERITAGE NURSING HOME INC					
HERITAGE HEALTHCARE CENTER	104,319				104,319
TOTALS	104,319				104,319

TOTALS (Should Tie to Totals on Page 13)

HERITAGE NURSING HOME INC	198,553	32,422	16,187	(16,235)	72,949
HERITAGE HEALTHCARE CENTER	291,771		18,152	18,152	287,258
TOTALS	490,324	32,422	34,339	1,917	360,207

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 217 Description: PITNEY BOWES-POSTAL MACHINE
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 7,903	$		$ 7,903	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,477			2,477	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			9,238			9,238	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				20,407		20,407	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2					4,379		4,379	12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**					1,069	12,988		14,057	13
14	TOTAL			$		$ 20,687	$ 37,774		$ 58,461	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	AIR FLUIDIZED BEDS	444
2	LABORATORY	1,049
3	MEDICAL SUPPLIES	11,495
4		
5		
6		
7		
8		
9		
10		
		12,988

	Outside Therapies (Column 5 - Other)	Amount
1	RESPIRATORY THERAPY	1,069
2		
3		
4		
5		
6		
7		
8		
9		
10		
		1,069

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 297,776	$ 297,776	1
2	Cash-Patient Deposits	41,248	41,248	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	605,069	605,069	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,992	15,992	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	36,165	77,444	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 996,250	$ 1,037,529	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		105,600	13
14	Buildings, at Historical Cost		1,878,400	14
15	Leasehold Improvements, at Historical Cos	231,681	384,994	15
16	Equipment, at Historical Cost	261,538	537,881	16
17	Accumulated Depreciation (book methods)	(232,591)	(1,158,579)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		1,250	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 260,628	$ 1,749,546	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,256,878	$ 2,787,075	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 214,061	$ 214,061	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	41,248	41,248	28
29	Short-Term Notes Payable	507,459	507,459	29
30	Accrued Salaries Payable	175,362	175,362	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,647	9,647	31
32	Accrued Real Estate Taxes(Sch.IX-B)		144,244	32
33	Accrued Interest Payable		9,191	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	360,416	1,037,656	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,308,193	$ 2,138,868	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,624	2,624	39
40	Mortgage Payable		1,141,996	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	4,022	4,022	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,646	$ 1,148,642	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,314,839	$ 3,287,510	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (57,961)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,256,878	$ #REF!	48

*(See instructions.)

Facility Name & ID Number HERITAGE NURSING HOME, INC. **#** 0038620 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
EMPLOYEE ADVANCES	36,165	36,165
REAL ESTATE TAX DEPOSIT		41,279
	36,165	77,444

OTHER CURRENT LIABILITIES:	Amount	Amount
DUE TO SUPERIOR MGMT	360,416	360,416
DUE TO R&S ASSOCIATES		677,240
	360,416	1,037,656

OTHER NON CURRENT ASSETS:		
Construction In Progress		
INVESTMENTS		1,250
		1,250

OTHER NON CURRENT LIABILITIES:		
DEFERRED INCOME TAX	4,022	4,022
	4,022	4,022

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (74,428)	1
2	Restatements (describe):		2
3	Schedule attached	(22,199)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (96,627)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	38,666	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 38,666	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (57,961)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	HERITAGE NURSING HOME, INC.	#	0038620	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(96,627)
Adjustments:		
		-
		-
		-
INCOME-GLUCOSE		(20,280)
INCOME-PART B		(6,283)
BAD DEBT		57,312
MANAGEMENT FEES		1,683
DEFERRED TAXES		(7,143)
LEGAL		(3,090)
Total adjustments		22,199
Balance - Beginning of Year		(74,428)
Equity(Deficit) from Page 17 Col 1		(57,961)
Related Party		
Equity(Deficit)	-600355	
Income	157881	
		(442,474)
Combined Equity - End of Year		(500,435)

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,758,596	1
2	Discounts and Allowances for all Levels	(89,941)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,668,655	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	41,376	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 41,376	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	20,906	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,102	19
20	Radiology and X-Ray		20
21	Other Medical Services	24,477	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 47,485	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,645	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,645	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,777,161	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	660,880	31
32	Health Care	1,206,514	32
33	General Administration	1,121,435	33
	B. Capital Expense		
34	Ownership	551,596	34
	C. Ancillary Expense		
35	Special Cost Centers	127,798	35
36	Provider Participation Fee	70,272	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,738,495	40
41	**Income before Income Taxes (line 30 minus line 40)****	38,666	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 38,666	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HERITAGE NURSING HOME, INC # 0038620 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,048	2,288	$ 58,504	$ 25.57	1
2	Assistant Director of Nursing	1,740	2,088	43,642	20.90	2
3	Registered Nurses	23,415	27,875	463,557	16.63	3
4	Licensed Practical Nurses	2,585	3,088	43,999	14.25	4
5	Nurse Aides & Orderlies	45,240	56,782	357,304	6.29	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,602	6,669	56,450	8.46	8
9	Activity Director					9
10	Activity Assistants	6,603	7,001	52,782	7.54	10
11	Social Service Workers	1,912	2,160	28,702	13.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,047	16,387	126,511	7.72	15
16	Dishwashers					16
17	Maintenance Workers	2,356	2,572	29,822	11.59	17
18	Housekeepers	11,664	12,871	93,255	7.25	18
19	Laundry	5,079	5,417	38,977	7.20	19
20	Administrator	1,838	2,089	91,538	43.82	20
21	Assistant Administrator	1,504	1,709	17,888	10.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,397	13,082	93,872	7.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,518	2,737	21,239	7.76	31
32	Other Health Care(specify)					32
33	Other(specify)	2,043	2,462	65,000	26.40	33
34	TOTAL (lines 1 - 33)	142,591	167,277	$ 1,683,042 *	$ 10.06	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 4,922	1-3	35
36	Medical Director	MONTHLY	2,400	9-3	36
37	Medical Records Consultant	MONTHLY	3,984	10-3	37
38	Nurse Consultant	44	2,200	10-3	38
39	Pharmacist Consultant	MONTHLY	1,645	10-3	39
40	Physical Therapy Consultant	51	2,523	10A-3	40
41	Occupational Therapy Consultant	40	1,992	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	92	3,794	11-3	44
45	Social Service Consultant	91	4,908	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	318	$ 28,368		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	78	$ 2,735	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	78	$ 2,735		53

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING SALARIES	2,043	2,462	$ 65,000	$ 26.40
	2,043	2,462	$ 65,000	$ 26.40

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SYLVIA HERLIHY	ADMINISTRATOR	NONE	$ 91,538
LAMINA RICHARDSON	ASST ADMIN	NONE	17,888
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 109,426

B. Administrative - Other

Description	Amount
DANIEL SHABAT-MGT FEE	$ 257,358
PRO HEALTH-MGT FEE	5,520
SYLVIA HERLIHY-MGT FEE	1,290
TOTAL (agree to Schedule V, line 17, col. 3)	$ 264,168
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FUTURE ASSOCIATES	ADMINISTRATIVE	$ 46,000
FR&R	ACCOUNTING	48,945
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	480
ECONOCARE	PURCHASING CNSLT	2,304
SACHNOFF & WEAVER	LEGAL	3,038
EUGENE L. GRIFFIN	LEGAL	3,233
MARTY SCHULTZ	LEGAL	1,000
LAWRENCE SCHWARTZ	LEGAL	2,340
LONG TERM COMP SYS	COMPUTER SUPPORT	929
SENIOR LIVING SYS	COMPUTER SUPPORT	5,550
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 113,819

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,910
Unemployment Compensation Insurance	9,665
FICA Taxes	124,608
Employee Health Insurance	95,308
Employee Meals	31,769
Illinois Municipal Retirement Fund (IMRF)*	
PENSION CONTRIBUTION	11,581
HOLIDAY EXPENSE	12,471
CHICAGO HEAD TAX	3,852
TOTAL (agree to Schedule V, line 22, col.8)	$ 310,164

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,928
Health Care Worker Background Check	
(Indicate # of checks performed 34)	356
IL COUNCIL ON LONG TERM CARE	4,797
LICENSES AND FEES	1,645
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,926

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,090
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,090

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HERITAGE NURSING HOME, INC. # 0038620 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NURSES AIDES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG CARE-4,797

(3) Did the nursing home make political contributions or payments to a politica action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? NA

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,264 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. NA

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
HERITAGE HEALTHCARE CENTER, 38620, 11/1/92

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ 70,272
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ 31,769 Has any meal income been offset against related costs? NA Indicate the amount. $ NA

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ NA
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? NA
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? NA
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? NA
g. Does the facility transport residents to and from day training? NA
Indicate the amount of income earned from providing such transportation during this reporting period. $ NA

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: NA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NA If no, please explain. NA

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw